FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038661

Facility Name: VIP Manor

Address: 393 Edwardsville Road (Number) Wood River (City) 62095 (Zip Code)

County: Madison

Telephone Number: (618) 259-4111 **Fax #** (618) 259-5791

IDPA ID Number: 95-3750883014

Date of Initial License for Current Owners: 12/31/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Greg LeRoy **Telephone Number:** (479) 201-4371

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/30/04 (Date)
(Type or Print Name) Greg Swartz
(Title) Assistant Secretary

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,367	7,347	2,861	12,575	8
9	SNF/PED					9
10	ICF	22,954			22,954	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,321	7,347	2,861	35,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.83%

D. How many bed-hold days during this year were paid by Public Aid?
314 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 2,861

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: #######

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	166,912	12,297	760	179,970		179,970	1,412	181,382			1
2	Food Purchase		153,644		153,644		153,644	(8,819)	144,825			2
3	Housekeeping		76	93,995	94,071		94,071	848	94,919			3
4	Laundry		7,210	62,811	70,022		70,022	(385)	69,637			4
5	Heat and Other Utilities			112,989	112,989	1,112	114,101		114,101			5
6	Maintenance	28,136	7,267	37,260	72,663		72,663	391	73,054			6
7	Other (specify):*			4,968	4,968		4,968		4,968			7
8	**TOTAL General Services**	195,049	180,494	312,784	688,327	1,112	689,439	(6,553)	682,886			8
	B. Health Care and Programs											
9	Medical Director			24,316	24,316		24,316	(236)	24,080			9
10	Nursing and Medical Records	1,309,227	53,906	110,008	1,473,141		1,473,141	(27,747)	1,445,394			10
10a	Therapy		226	222,852	223,078		223,078	(61,533)	161,545			10a
11	Activities	36,742	2,878	472	40,092		40,092	52	40,144			11
12	Social Services	31,443	621	2,395	34,459		34,459	(569)	33,890			12
13	Nurse Aide Training			1,049	1,049	(1,049)	0		0			13
14	Program Transportation			4,076	4,076		4,076	(151)	3,925			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,377,411	57,630	365,170	1,800,211	(1,049)	1,799,162	(90,184)	1,708,978			16
	C. General Administration											
17	Administrative			249,730	249,730	77,666	327,396	36,917	364,313			17
18	Directors Fees											18
19	Professional Services			1,251	1,251		1,251		1,251			19
20	Dues, Fees, Subscriptions & Promotions			15,311	15,311		15,311	(3,765)	11,546			20
21	Clerical & General Office Expenses	120,106	12,865	74,448	207,419	(74,496)	132,923	(54,570)	78,353			21
22	Employee Benefits & Payroll Taxes			330,012	330,012		330,012	14,144	344,156			22
23	Inservice Training & Education			145	145	1,049	1,194		1,194			23
24	Travel and Seminar			12,279	12,279	(441)	11,838	(208)	11,630			24
25	Other Admin. Staff Transportation			209	209		209		209			25
26	Insurance-Prop.Liab.Malpractice			99,980	99,980		99,980	62,951	162,931			26
27	Other (specify):*	447		2,706	3,153		3,153	(3,153)	0			27
28	**TOTAL General Administration**	120,553	12,865	786,072	919,489	3,778	923,267	52,316	975,583			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,693,013	250,988	1,464,026	3,408,026	3,841	3,411,867	(44,421)	3,367,446			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number VIP Manor 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,950	72,950		72,950	5,324	78,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40	40		40		40			32
33	Real Estate Taxes			61,338	61,338		61,338	54,899	116,237			33
34	Rent-Facility & Grounds			522,195	522,195		522,195		522,195			34
35	Rent-Equipment & Vehicles			28,017	28,017	(3,841)	24,176	(239)	23,937			35
36	Other (specify):*											36
37	**TOTAL Ownership**			684,540	684,540	(3,841)	680,699	59,984	740,683			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,745	160	85,905		85,905	(85,905)	(0)			39
40	Barber and Beauty Shops			2,032	2,032		2,032	(2,032)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							62,964	62,964			42
43	Other (specify):*		11,429	8,493	19,922		19,922	(19,922)	0			43
44	**TOTAL Special Cost Centers**		97,174	10,685	107,859		107,859	(44,895)	62,964			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,693,013	348,163	2,159,250	4,200,425		4,200,425	(29,332)	4,171,093			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,862)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,853)	27		18
19	Entertainment				19
20	Contributions	(509)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,328)	21		24
25	Fund Raising, Advertising and Promotional	(4,514)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(4,866)	5A		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,089)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(21,146)	17	34
35	Other- Attach Schedule	52,903		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31,757		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (29,332)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

VIP Manor

ID# 0038661

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UR Fees	$ 0		1
2	Barber & Beauty			2
3	Patient Loss	0	27	3
4	Vendor Service Charge	(811)	27	4
5	Bank Service Charge	(1,367)	21	5
6	Magical Moments	0	20	6
7	Additional Facility Rent	0	34	7
8	Corporate Collection Fees	(1,704)	21	8
9	Patient Personal Supplies	(984)	10,27	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,866)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	1,412	0	0	0	0	0	0	0	0	0	0	1,412	1
2	Food Purchase	(8,819)	0	0	0	0	0	0	0	0	0	0	(8,819)	2
3	Housekeeping	848	0	0	0	0	0	0	0	0	0	0	848	3
4	Laundry	(385)	0	0	0	0	0	0	0	0	0	0	(385)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	391	0	0	0	0	0	0	0	0	0	0	391	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,553)	0	0	0	0	0	0	0	0	0	0	(6,553)	8
	B. Health Care and Programs													
9	Medical Director	(236)	0	0	0	0	0	0	0	0	0	0	(236)	9
10	Nursing and Medical Records	(27,747)	0	0	0	0	0	0	0	0	0	0	(27,747)	10
10a	Therapy	(61,533)	0	0	0	0	0	0	0	0	0	0	(61,533)	10a
11	Activities	52	0	0	0	0	0	0	0	0	0	0	52	11
12	Social Services	(569)	0	0	0	0	0	0	0	0	0	0	(569)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(151)	0	0	0	0	0	0	0	0	0	0	(151)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(90,184)	0	0	0	0	0	0	0	0	0	0	(90,184)	16
	C. General Administration													
17	Administrative	36,917	0	0	0	0	0	0	0	0	0	0	36,917	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,765)	0	0	0	0	0	0	0	0	0	0	(3,765)	20
21	Clerical & General Office Expenses	(54,570)	0	0	0	0	0	0	0	0	0	0	(54,570)	21
22	Employee Benefits & Payroll Taxes	14,144	0	0	0	0	0	0	0	0	0	0	14,144	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(208)	0	0	0	0	0	0	0	0	0	0	(208)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	62,951	0	0	0	0	0	0	0	0	0	0	62,951	26
27	Other (specify):*	(3,153)	0	0	0	0	0	0	0	0	0	0	(3,153)	27
28	**TOTAL General Administration**	52,316	0	0	0	0	0	0	0	0	0	0	52,316	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,421)	0	0	0	0	0	0	0	0	0	0	(44,421)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VIP Manor # 0038661 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,324	0	0	0	0	0	0	0	0	0	0	5,324	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	54,899	0	0	0	0	0	0	0	0	0	0	54,899	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(239)	0	0	0	0	0	0	0	0	0	0	(239)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	59,984	0	0	0	0	0	0	0	0	0	0	59,984	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(85,905)	0	0	0	0	0	0	0	0	0	0	(85,905)	39
40	Barber and Beauty Shops	(2,032)	0	0	0	0	0	0	0	0	0	0	(2,032)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	62,964	0	0	0	0	0	0	0	0	0	0	62,964	42
43	Other (specify):*	(19,922)	0	0	0	0	0	0	0	0	0	0	(19,922)	43
44	**TOTAL Special Cost Centers**	(44,895)	0	0	0	0	0	0	0	0	0	0	(44,895)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,332)	0	0	0	0	0	0	0	0	0	0	(29,332)	45

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services	100	More than 370 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Stategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, Inc.	Fort Smith, AR	Nursing Staffing
				CSMS, Inc.	Fort Smith, AR	Purchasing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office Costs	$ 248,823	Beverly Health & Rehabilitation Services	100.00%	$ 277,267	$ 28,444	1
2	V	10	Nursing Consultant	30,037	Beverly Health & Rehabilitation Services	100.00%	35,010	4,973	2
3	V	01	Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	1,616	1,616	3
4	V	12	Housekeeping Consultant	0	Beverly Health & Rehabilitation Services	100.00%	848	848	4
5	V								5
6	V	10a	Therapy Expense/Home Office	222,852	Aegis Therapies, Inc.	100.00%	161,319	(61,533)	6
7	V	27	Home Office Costs	0	Ceres Strategies, Inc.	100.00%	4,506	4,506	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 501,712			$ 480,566	$ * (21,146)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehabilitation Services
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (479) 201-2000
Fax Number: (479) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corp Home Office/QA Cost	Resident Days	86,645	3	$ 670,276	$ 310,261	35,843	$ 277,277	1
2										2
3	10	Corp Home Office Cost-Nursing	Resident Days	86,645	3	0	0	35,843	0	3
4	10	Corp QA Cost - Nursing	Resident Days	86,645	3	84,626	70,554	35,843	35,008	4
5										5
6	01	Corp QA Cost - Dietary	Resident Days	86,645	3	3,907	2,941	35,843	1,616	6
7										7
8	12	Corp QA Cost - Social Services	Resident Days	86,645	3	2,050	1,391	35,843	848	8
9										9
10	10a	Therapy/Home Office	Facility Specific		2	310,344	0	0	161,320	10
11										11
12	17,10,02	Corp Home Office	Facility Specific		3	9,094	0	0	4,506	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24		Rounding							(9)	24
25	TOTALS					$ 1,080,297	$ 385,147		$ 480,566	25

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3	CCA Financial, Inc.		X	Equipment Acquisition							42	3
4	(Turbolan)											4
5												5
	Working Capital											
6												6
7	Interest Income		X								(2)	7
8												8
9	TOTAL Facility Related						$	$			$ 40	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 40	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 32,513 Line # 34

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	61,134	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	116,237	2
3. Under or (over) accrual (line 2 minus line 1).	$	55,103	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,134	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	116,237	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	93,348	8
1999	99,390	9
2000	108,742	10
2001	115,370	11
2002	116,237	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VIP Manor COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0038661

CONTACT PERSON REGARDING THIS REPORT Greg LeRoy

TELEPHONE (479) 201-4371 FAX #: (479) 201-4302

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-2-08-22-14-302-011	Encore VIP Manor IL LLC.	$ 116,237.00	$ 116,237.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,237.00	$ 116,237.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	LEASEHOLD IMPROVEMENTS			1993	59,410	4,814	5-20	4,814		52,326	10
11	(See depreciation schedule for asset detail of items acquired 1993 - 1999)			1994	87,778	7,378	5-20	7,378		75,761	11
12				1995	165,318	10,114	5-20	10,114		102,701	12
13				1996	2,061	72	5-20	72		1,493	13
14				1997	57,881	4,764	5-20	4,764		40,275	14
15				1998	20,995	1,585	5-20	1,585		8,932	15
16				1999	11,194	925	5-20	925		4,123	16
17	DISH MACHINE			2000	1,431	143	10	143		573	17
18	DISPOSAL			2000	1,265	253	5	253		991	18
19	REPL:COMPRESSOR A-C UNIT			2000	627	42	15	42		157	19
20	ROOF REPAIR			2000	34,344	3,434	10	3,434		12,593	20
21	CONSTRUCTION INTEREST			2000	406	27	15	27		99	21
22	CONTRACTOR PAY REQUESTS			2000	24,300	1,620	15	1,620		5,940	22
23	REPL MOTOR DISHWASHER			2000	1,304	261	5	261		935	23
24											24
25	NEW NURSE CALL SYSTEM			2001	9,677	968	10	968		2,742	25
26	INST'L OF DOOR MONITORING			2001	11,436	1,144	10	1,144		3,145	26
27	REPL MOTOR/DISHWASHER			2001	1,303	261	5	261		695	27
28	TRANSFORMER			2001	104	10	10	10		28	28
29	ADD'L SPRINKLER SYS/CANOPY			2001	3,200	213	15	213		551	29
30	INSTALLATION			2001	1,559	156	10	156		377	30
31	WHEELCHAIR RAMP			2001	500	33	15	33		72	31
32	FENCE- CHAIN LINK			2001	1,243	83	15	83		180	32
33	DISPOSAL			2001	1,296	259	5	259		540	33
34				2001							34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOOR W/FRAME-DINING ROOM	2002	$ 760	$ 76	10	$ 76	$	$ 127	37
38	CONSTRUCTION INTEREST	2002	912	61	15	61		91	38
39	FIXED EQUIPMENT-15 YEAR LIFE	2002	32,296	2,153	15	2,153		3,230	39
40	REPL CONDENSOR/2DR COOLER	2002	920	61	15	61		72	40
41		2002							41
42		2002							42
43		2002							43
44		2002							44
45		2002							45
46		2002							46
47									47
48	CONTRACTOR PAY REQUESTS	2003	6,113	340	15	340		340	48
49	2 KEYPADS	2003	824	32	15	32		32	49
50	2.5TON CENTRAL AIR UNIT	2003	2,817	282	5	282		282	50
51	THERMO MIXING VALVE,MIX CA	2003	1,777	30	15	30		30	51
52	3.5 TON UNIT/NORTH WING	2003	2,817	141	5	141		141	52
53	7.5 TON UNIT/DIETARY	2003	6,380	160	10	160		160	53
54	LAN DROP	2003	525		15				54
55		2003							55
56		2003							56
57		2003							57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 554,775	$ 41,895		$ 41,895	$	$ 319,730	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 294,284	$ 33,153	$ 33,153	$	5-10	$ 179,970	71
72	Current Year Purchases	14,848	3,225	3,225		5-10	3,225	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 309,133	$ 36,378	$ 36,378	$		$ 183,196	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 863,907	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,274	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 78,274	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 502,925	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		106	12/31/85	$ 522,195	5	30	3
4	Additions							4
5								5
6								6
7	TOTAL		106		$ 522,195 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purchase of all Encore facilities *

10. Effective dates of current rental agreement:
Beginning 12/31/01
Ending 12/31/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/04	$ 564,931
13.	12/31/05	$ 564,931
14.	12/31/06	$ 564,931

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevrolet E-350	$ 721	$ 8,657	17
18					18
19					19
20					20
21	TOTAL		$ 721	$ 8,657	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,238	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,917)	431,855		3
4	Supply Inventory (priced at Historical Cost)	29,284		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	73,800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 537,177	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	106,172		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	554,775		15
16	Equipment, at Historical Cost	309,133		16
17	Accumulated Depreciation (book methods)	(502,925)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 467,154	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,004,331	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 55,450	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,159		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,220		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,478		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Contingencies			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 200,307	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	(1,595,159)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,595,159)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,394,851)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,399,182	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,004,331	$	48

***(See instructions.)**

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,510,489	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,510,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,307)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Cost Report Equity Adjustments**	0	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (111,307)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,399,182	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,989,104	1
2	Discounts and Allowances for all Levels	(402,043)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,587,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	307,662	6
7	Oxygen	17,327	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 324,989	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,125	13
14	Non-Patient Meals	5,546	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,990	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,769	19
20	Radiology and X-Ray	3,485	20
21	Other Medical Services	66,272	21
22	Laundry	5,580	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,767	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Pat Pers Needs, Other Misc. Rev	2,301	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,301	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,089,118	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	688,327	31
32	Health Care	1,800,211	32
33	General Administration	919,489	33
	B. Capital Expense		
34	Ownership	684,540	34
	C. Ancillary Expense		
35	Special Cost Centers	44,895	35
36	Provider Participation Fee	62,964	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,200,425	40
41	**Income before Income Taxes (line 30 minus line 40)****	(111,307)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (111,307)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,048	$ 53,050	$ 25.90	1
2	Assistant Director of Nursing	1,621	1,725	34,098	19.77	2
3	Registered Nurses	7,971	8,290	156,031	18.82	3
4	Licensed Practical Nurses	21,479	22,751	359,402	15.80	4
5	Nurse Aides & Orderlies	69,070	74,740	662,241	8.86	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,885	2,146	20,375	9.50	9
10	Activity Assistants	1,792	2,025	17,426	8.60	10
11	Social Service Workers	5,162	5,805	54,308	9.36	11
12	Dietician	0	275	5,903	21.51	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	19,426	20,338	145,521	7.16	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,406	2,547	29,550	11.60	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	2,272	2,368	77,225	32.61	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,991	2,697	28,610	10.61	22
23	Office Manager	1,892	2,174	32,918	15.14	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,804	1,956	16,355	8.36	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) DSD Cooridnator	0	0	0		33
34	TOTAL (lines 1 - 33)	140,635	151,885	$ 1,693,013 *	$ 11.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 760	1-3	35
36	Medical Director		24,316	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		35,010	10-3	38
39	Pharmacist Consultant		5,344	10-3	39
40	Physical Therapy Consultant		0	N/A	40
41	Occupational Therapy Consultant		0	N/A	41
42	Respiratory Therapy Consultant		0	N/A	42
43	Speech Therapy Consultant		0	N/A	43
44	Activity Consultant		472	11-3	44
45	Social Service Consultant		1,390	12-3	45
46	Other(specify) Hskpg/Laundry		170,154	3,4	46
47	Maintenance		13,645	6	47
48	Profess,MedWaste, Transport		689	6,19	48
49	TOTAL (lines 35 - 48)		$ 251,781		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		45,562		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$ 45,562		53

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jamie Ziegler	Executive Director	0	$ 9,153
Veronica Judd	Executive Director	0	6,731
Claire Brannon	Executive Director	0	2,800
John Munch	Executive Director	0	36,676
Charles Keigley	Executive Director	0	12,000
Dallas Larson	Executive Director	0	4,615
Bruce Vaca	Executive Director	0	5,250
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,225

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Corporation Service Co. Inc.	Legal	$ 338
HR Solutions	Human Resource	286
Deloitte & Touche, LLP.	Accounting	628
	Adjustments	0
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 1,251

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,242
Unemployment Compensation Insurance	0
FICA Taxes	0
Employee Health Insurance	77,648
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Injury	0
Payroll Taxes	147,922
Retirement Expense	(74)
Employee Fringe Benefits	1,472
Workers' Compensation Insurance Adjustment	14,766
Medical/Dental Ins Adjustment	(5,820)
Rounding	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 344,156

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 907
Advertising: Employee Recruitment	2,264
Health Care Worker Background Check	2,588
(Indicate # of checks performed 0)	
Dues and Subscriptions	8,193
Advertising and Public Relations	1,337
Community Education	2,611
Reclass Miscoded Expense	0
Less: PAC Fees/Contributions	(509)
Less: Public Relations Expense	( )
Non-allowable advertising	(5,844)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,546

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,018
Meals	2,612
Personal ED Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,630

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number VIP Manor **#** 0038661 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association** **$4,928**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,964**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,862**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Beverly is a publicly traded company audited as a wh**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.